Utah Department of Health
IMMUNIZATION PROGRAM
Immunize for healthy lives

Perinatal Hepatitis B Prevention Program
Case Report Form

Mother's Information:	**Expected Delivery:**	**Actual Delivery:**
Last Name: _____	Date:	Date:
First Name: _____	Hospital:	Hospital:
Address: _____	**Lab Results:**	**Primary Care Provider:**
City: _____ Zip: _____	HBsAg #1 Date: _____	Name: _____
Home Phone: (_____)_____	Result (+ / -) : _____	Address: _____
Work Phone: (_____)_____	Lab:	Phone: _____
DOB: _____ Age: _____	**Race:**	Case Worker:
County: _____ Health District: _____	❑ Asian ❑ Pacific Islander ❑ Black ❑ White ❑ American Indian ❑ Alaskan Native ❑ Other	Phone:

Infant's Information:	**Immunization Dates:**	**Post Serological Testing:**	**Primary Care Provider:**
Last Name: _____	HBIG _____	HBsAg Date: _____	Name: _____
First Name: _____	HBV #1 _____	Result (+ / -) : _____	Address: _____
DOB: _____	HBV #2 _____	Anti-HBs Date: _____	Phone: _____
Gender: _____	HBV #3 _____	Result (+ / -) : _____	
	HBV #4 _____	Lab:	

Contact Name	**DOB**	**Age**	**Gender**	**HBsAg Date (+ / -)**	**Anti-HBs Date (+ / -)**	**HBIG Date**	**HBV #1 Date**	**HBV #2 Date**	**HBV#3 Date**

FOR INFORMATION: Call the Utah Immunization Program (801) 538-9450, FAX Number (801) 538-9440
Send a copy to Utah Immunization Program as soon as a case is identified and with each update.
Retain a copy in your permanent files